

Case: _____ Control: _____

Date Received: _____

Type/Source: _____ / _____

Org. Code: _____

Report of Accident/Illness

SAFETY & HEALTH MANAGEMENT INFORMATION

TO BE COMPLETED BY EMPLOYEE

1. Reason for Report:

☐

Accident

☐

Illness

2. Name: _____
(Last, First, M.I.)

3. SSN: _____

4. Occupation: _____

5. Phone: _____

6. Date of Birth: _____

7. Sex: ☐ Male ☐ Female

8. Date/Time of Accident/Illness: _____ Time: _____ ☐ AM ☐ PM

9. Duty Station Address: _____

10. Location of Incident: _____

11. Description of Incident: _____

12. Extent of Injury or Illness and Body Parts Affected: _____

Signature: _____ Date: _____

TO BE COMPLETED BY EMPLOYEE'S SUPERVISOR

13. Medical Treatment? ☐ Yes ☐ No

14. Lost Time? ☐ Yes ☐ No

15. Investigator's Name: _____

15. Investigation Date: _____

16. Findings: _____

17. Amount of Property Damage: \$ _____

18. Corrective Action: _____

19. Completion Date: _____ ☐ Estimated ☐ Actual

Investigator's Signature: _____ Date: _____

Title: _____ Phone: _____